IOWA WORKFORCE DEVELOPMENT
Smart. Results.

Division of Labor Services

**Office Use Only**

Date Rec._____

Time Rec._____

Initials_____

Elevator, Boiler, and Amusement Ride Bureau
1000 East Grand Avenue
Des Moines, Iowa 50319-0209
Ph#: 515-281-5415 or 515-281-3418 FAX: 515-242-5076

# CONVEYANCE ACCIDENT REPORT

| **Building Name** | **Owner's Name** | **Owner's ID** |
|---|---|---|
| **Building Street Address** | **Owner's Address** | **State ID** |
| **City, State, Zip** | **City, State, Zip** | **Manufacturer** |

**875—71.3(89A) Accident Reports -** The owner or duly authorized agent shall immediately notify the commissioner of each and every personal injury accident requiring the service of a physician or causing disability exceeding one day or causing damage to the conveyance exceeding $2,000. Notification shall be in writing, and shall specifically identify the conveyance, state identification number, owner, and description of accident. When an accident involves the failure or destruction of any part of the conveyance or the operating mechanism of a device, the use of the device is forbidden until it has been made safe and until it has been reinspected and any repairs or alterations have been approved by the commissioner. The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden until permission to do so has been granted by the commissioner.

**Type of Conveyance**

**Escalator** ☐ **Elevator** ☐ **Special Purpose** ☐ **Other** ☐_____

**Describe fully how accident occurred and state what injured was doing when the accident occurred:**

Are there any videotapes or photographs of the incident? ☐ Yes ☐ No (if yes, please mail copies)

Were safety orders issued at the last inspection? ☐ Yes ☐ No

Are repairs needed now? ☐ Yes ☐ No (Detail Repairs Needed)

Does the conveyance have a Permit to Operate? ☐ Yes ☐ No

Date of Last Inspection:

Has conveyance been secured from operation? ☐ Yes ☐ No If no, why?

Conveyance Contractor Notified: ☐Yes ☐No
If Yes, Company Contact(s) and Telephone Number(s)

| WITNESS(ES) | | | |
|---|---|---|---|
| **Name** | **Address** | **Phone #** | **Approx. Age** |
| | | | |

**Number of people injured:**

*****Please complete a set of questions for each injured person*****

**Name of 1st injured**: Age: Date of injury: Time of injury:

Address:

City: State: Telephone:

Were injuries to this person fatal ☐ Yes ☐ No | Did injury to this person require hospitalization? ☐ Yes ☐ No

Did injury to this person require first aid? ☐ Yes ☐ No

Nature of injury:

**Name of 2nd injured**: Age: Date of injury: Time of injury:

Address:

City: State: Telephone:

Were injuries to this person fatal ☐ Yes ☐ No | Did injury to this person require hospitalization? ☐ Yes ☐ No

Did injury to this person require first aid? ☐ Yes ☐ No

Nature of injury:

**Name of 3rd injured:** Age: Date of injury: Time of injury:

Address:

City: State: Telephone:

Were injuries to this person fatal ☐ Yes ☐ No | Did injury to this person require hospitalization? ☐ Yes ☐ No

Did injury to this person require first aid? ☐ Yes ☐ No

Nature of injury:

***I hereby certify pursuant to the laws of the State of Iowa that the above information is true and correct to the best of my knowledge and belief.***

| Name of Person Filing Report (Please Print Clearly) | Company or Firm |
|---|---|
| Signature of Person Filing Report | Date of this Report |

*For Office Use Only*

Acquired Written Report from First Responder (if applicable) ☐ Acquired Hospital Report (if applicable) ☐

Report Filed Immediately w/ Division of Labor Services ☐